1. Implement actions indicated under goals 6 and 7.
2. Gather information from additional tools providing behavioral information, such as the Behavioral Risk Factor Survey.
3. Expand data analytic capabilities for linking sources of exposure to EBLLs.
4. Improve data collection and utilize information on the newly expanded follow-up form for case management and environmental reporting.
5. Obtain support from other programs such as housing, environmental agencies, and local lead programs.

During year two, *DHS and partners should:*

1. Begin to define associations between potential sources of lead exposure and blood lead levels, geographic areas, populations, and health program groups at risk.
2. Begin to use information to develop policy strategies, as indicated.

During years three through five, *DHS and partners should:*

1. Implement policy strategies, as indicated.

Evaluation: Year one– Development of analytic and data capture capabilities. Year two– Definition of associations between lead exposures and blood lead levels, areas and populations at risk; and development of policies. Years three through five– Continuation of earlier activities and implementation of policies.

PLANNING AREA FOUR: SCREENING

OVERVIEW OF ISSUES RAISED

Screening for lead poisoning (blood lead testing) is a secondary prevention strategy, to identify children who already have elevated blood lead levels and to see that they receive appropriate follow-up, medical services, and public health case management. While universal laboratory reporting of blood lead test results indicates that more children are being tested for lead poisoning than has been previously recognized, large numbers of children still are not being screened in accordance with current medical provider regulations. By regulation, medical providers are responsible for screening and for informing families of blood lead test results and approaches to reducing exposures. Accountability measures and monitoring may be needed. To increase screening, we also need to make screening more accessible and easily performed. We need to assure that the desired population, currently considered at risk for lead poisoning, receives screening. Other collaborative models for increasing screening, such as with other screening programs (e.g., immunization), or in combination with home visiting or housing inspections, should be explored. Expanding of screening to include pregnant women should be considered, so that early identification, follow-up and interventions can be assured for at-risk infants.

The following screening goals have been identified as priorities for the strategic plan, along with objectives and action steps to achieve the goals over the next five years:

GOAL 9: Achieve maximal blood lead testing of groups currently targeted for screening.

Objective 9.1. Achieve full screening and reporting of information under current targeted screening plan for several years to achieve information on this population.

Objective 9.2. Expand data partnerships with health programs, such as Medi-Cal, CHDP, and WIC, to determine program screening rates.

Action Steps for Objectives 9.1 and 9.2

During years one and two, *DHS should:*

1. Develop strategies to get lead message across to healthcare providers, so that screening is achieved, and partner with professional medical and nurse practitioner organizations.
2. Work with health programs, such as Medi-Cal, CHDP, WIC, and immunization, to achieve maximal collaborations and implementation of current blood lead screening plan.
3. Work with healthcare providers and laboratories to facilitate ease of blood lead testing.
4. Work with clinical laboratories, laboratory associations, and healthcare providers to assure full reporting of blood lead tests and testing information.
5. Work with local lead programs and community organizations to maximize implementation of screening plan.
6. Use information from screening to determine lead screening rates in health programs, geographic areas, and population groups and to target programs and areas to increase screening, as needed.

During years three through five, *DHS and healthcare partners should:*

1. Continue to maximize screening under screening plan in effect.

Evaluation: Years one and two and ongoing in years three through five– Evidence of collaboration with partners and screening rates achieved; implementation of targeting specific areas.

GOAL 10: Define whether the current targeted screening plan is the best model or whether the screening plan needs to be modified.

Objective 10.1. Determine if the childhood population groups currently targeted for screening are at greatest risk for lead exposure and elevated blood lead levels, or whether the target groups need to be further focused.

Objective 10.2. Determine whether targeting children age one and two years for screening is best model or whether screening should be carried out earlier to allow intervention and prevent further rise in blood lead levels.

Objective 10.3. Determine if current medical model for carrying out screening is best approach for achieving screening.

Action Steps for Objectives 10.1 through 10.3.

During years one and two, *DHS and health care partners should:*

1. Carry out data capture and analyses indicated in goals 6 through 9.
2. Determine groups at greatest for lead exposure and elevated blood lead levels.
3. Assess whether lead testing carried out before age one is predictive of later rise, and useful for intervention strategies.
4. Complete pilot prevalence study, which is currently underway, and analyze results to look for best approaches for carrying out screening and to see if there are groups of children being missed by current screening.
5. Improve access for screening.
6. Use additional testing results to determine if groups not currently targeted for screening should be, such as children of occupationally exposed workers.
7. Propose alternative screening plan and receive stakeholder input.
8. Develop new strategies for working with local lead programs and community groups to achieve screening, as appropriate.

During years three through five, *DHS and all partners should:*

1. Implement new screening plan and strategies, as indicated.

Evaluation: Years one and two– Measures as for goals 6 through 9, successful completion and analysis of pilot prevalence study; and development of new plan and strategies for working with partners. Years three through five– Implementation of new plan, as indicated; and evaluation of whether new plan is reaching new target groups.

GOAL 11: Evaluate whether expansion of screening to pregnant women or women of childbearing age will improve identification of children and populations at risk and result in prevention of fetal and early childhood exposure.

Objective 11.1. Use maternal and prenatal data to identify fetuses, children, and population groups at risk.

Objective 11.2. Use prenatal data to reduce fetal and newborn exposure to lead.

Action Steps for Objectives 11.1 and 11.2.

During years one and two, *DHS should:*

1. Develop partnerships with groups involved with pregnant women and women of childbearing age, such as Medi-Cal, Access for Infants and Mothers, obstetrical and gynecologic associations, the Maternal and Child Health Branch, and the Occupational Health Lead Poisoning Prevention Program.
2. Carry out data assessment of maternal- infant- child blood lead values.
3. Gather information on maternal- fetal- infant risks from lead exposure.
4. Consider pilot prenatal screening project with local lead programs.

During year three, *DHS and partners should:*

1. Develop screening policy for pregnant women and women of childbearing age, if appropriate.
2. Determine scope of services that should be provided to those identified through testing as having lead exposure.

During years four and five, *DHS should:*

1. Implement screening and service policies, as appropriate.

Evaluation: Years one and two– Success at developing partnerships; data and information assessments; prenatal screening project pilot. Year three– Development of policies and scope of services, as indicated. Years four and five– Implementation of screening policy as indicated; numbers of individuals identified and interventions achieved.

GOAL 12: Use surveillance and screening data to assess progress in elimination of EBLLs, determine need for future widespread screening, and whether California should move to a sentinel screening approach.

Objective 12.1. Ongoing assessment of prevalence of lead poisoning and children and communities at risk, to assess effectiveness of elimination plan efforts.

Objective 12.2. Define point at which prevalence of lead exposure has decreased such that widespread targeted screening may no longer be warranted.

Objective 12.3. Develop strategies for estimating distribution of blood leads and sources of lead, if blood lead testing is no longer indicated (sentinel screening).

Action Steps for Objectives 12.1. through 12.3.

During years one through three, *DHS should:*

1. Continue to collect surveillance data and develop policy strategies, as indicated under goals 6 through 8.
2. Look at measure of incidence of newly identified children with EBLLs, as best can be determined, as well as prevalence of EBLLs.

During years four and five, *DHS should:*

1. Use data collected to assess demographics of EBLLs and lead poisoning over time.
2. Use data collected to consider if and, if so, when program should move away from a targeted screening approach (screening all individuals in designated target populations) to a primary prevention model combined with limited sentinel screening.
3. Partner with local lead programs and CDC in evolving strategies and sentinel screening concepts.
4. Begin to implement new model, if indicated.

Evaluation: Years one through three– As for goals 6 through 8. Years four and five– achievement of analyses as to prevalence of lead poisoning, incidence rates, and factors that would indicate re-orientation of screening program.

PLANNING AREA FIVE: IDENTIFICATION AND MANAGEMENT OF LEAD-POISONED INDIVIDUALS